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No. ———

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

MICHELLE CISNEROS,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

Of Counsel:
TAMARRA T. RENNICK
Litigation Counsel
UNUM LIFE INSURANCE COMPANY OF AMERICA
2211 Congress Street
Portland, ME 04122
(207) 770-2211

LESLEY C. GREEN
RUSSELL G. PETTI
BANNAN, GREEN & FRANK LLP
555 South Flower Street
44th Floor
Los Angeles, CA 90017
(213) 362-1177

DAVID L. BACON
Counsel of Record
BENJAMIN I. DELANCY
CHARLES M. DYKE
THELEN, MARRIN, JOHNSON & BRIDGES LLP
333 South Grand Avenue
34th Floor
Los Angeles, CA 90071
(213) 621-9800
Attorneys for Petitioner UNUM Life Insurance Company of America

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QUESTIONS PRESENTED

1. Whether, in an opinion expressly acknowledging a circuit conflict—indeed, one affecting eight circuits—the Ninth Circuit erred in holding that a state law need not satisfy all three McCarran-Ferguson Act criteria for the business of insurance, and in particular the transfer of risk of loss, to be saved from preemption under ERISA.

2. Whether the Ninth Circuit—contrary to the law in nine other circuits—erred in holding that a state law survives ERISA preemption even though it conflicts not only with ERISA's requirement that fiduciaries administer all plans "in accordance with" their written terms, but also with ERISA's exclusive civil enforcement scheme by expanding the remedies beyond those expressly provided for in the Act.

PARTIES

The petitioner is UNUM Life Insurance Company of America ("UNUM"). The respondent is Michelle Cisneros.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that UNUM Corporation is the parent of UNUM. UNUM Corporation has two nonwholly owned subsidiaries, Boston Compania Argentina de Seguros S.A. and UNUM Delaware Company. UNUM Life Insurance Company of America has one nonwholly owned subsidiary, SP Administrator, LLC.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES	ii
TABLE OF AUTHORITIES	vi
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	1
STATEMENT OF THE CASE	1
A. Factual Background	1
B. The Complaint	2
C. The District Court's Decision	3
D. The Ninth Circuit's Decision	3
REASONS FOR GRANTING THE WRIT	6
I. THE NINTH CIRCUIT'S ERISA PREEMPTION DECISION CONFLICTS DIRECTLY WITH HOLDINGS IN THE THIRD, FIFTH, SEVENTH, EIGHTH, TENTH AND ELEVENTH CIRCUITS	6
II. THE NINTH CIRCUIT'S PREEMPTION DECISION CONFLICTS DIRECTLY WITH NINE OTHER CIRCUITS WHICH ENFORCE WRITTEN PLAN PROVISIONS SUCH AS NOTICE REQUIREMENTS	8
III. THE NINTH CIRCUIT'S PREEMPTION DECISION IS AN ATTEMPT TO CIRCUMVENT THIS COURT'S CONTROLLING *PILOT LIFE* DECISION	14

TABLE OF CONTENTS—Continued

Page

IV. THE NINTH CIRCUIT'S PREEMPTION DECISION COMPLETELY DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS 17

V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR ERISA PLANS THAT SHOULD BE ADDRESSED BY THIS COURT 22

CONCLUSION 26

APPENDIX:

Opinion of the Court of Appeals, filed January 20, 1998 ..... 1a

Notification by Supreme Court Clerk that Time to File Petition Was Extended by Justice O'Connor to May 20, 1998 ..... 16a

Order of the District Court Granting Summary Judgment, filed June 22, 1995 ..... 17a

Reporter's Transcript of the Proceeding Before District Court, June 19, 1995 ..... 21a

Declaration of Donald F. Jensen And Portion of Exhibits In Support of Motion to Dismiss Complaint, filed April 25, 1995 ..... 25a

State Court Complaint, filed March 1, 1995 ..... 42a

TABLE OF AUTHORITIES

CASES

Page

Anschultz v. Connecticut Gen'l Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) 7

Boggs v. Boggs, 520 U.S. ——, 117 S.Ct. 1754 (1997) 22, 26

Boyer v. Douglas Components Corp., 986 F.2d 999 (6th Cir. 1993) 11

Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150 (8th Cir. 1990) 7

Burnham v. Guardian Life Ins. Co. of America, 873 F.2d 486 (1st Cir. 1989) 11

Cefalu v. B.F. Goodrich Co., 871 F.2d 1290 (5th Cir. 1989) 11

CIGNA Healthplan v. Louisiana, 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996) 5, 6

Coleman v. Nationwide Life Ins. Co., 969 F.2d 54 (4th Cir. 1992), *cert. denied*, 506 U.S. 1081 (1993) 11

Curtis-Wright v. Schoonejongen, 514 U.S. 78 (1995) 10

Davies v. Centennial Life Ins. Co., 128 F.3d 934 (6th Cir. 1997) 6

DeBruyne v. Equitable Life Assur. Soc. of the U.S., 920 F.2d 457 (7th Cir. 1990) 7

Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869 (7th Cir. 1997) 11

Edwards v. Great-West Life Assur. Co., 20 F.3d 748 (7th Cir. 1994) 11

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 12

Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) 4, 6, 19, 20, 25

Heath v. Varity Corp., 71 F.3d 256 (7th Cir. 1995) 24

Howard v. Gleason Corp., 910 F.2d 1154 (2d Cir. 1990) 11

Hunt v. Hawthorne Associates, Inc., 119 F.3d 888 (11th Cir. 1997) 11

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1996) 17

TABLE OF AUTHORITIES—Continued

	Page
Insurance Bd. v. Muir, 819 F.2d 408 (3d Cir. 1987)	7
Kelley v. Sears, Roebuck & Co., 882 F.2d 453 (10th Cir. 1989)	7
Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985)	14
McMahon v. New England Mut. Life Ins. Co., 888 F.2d 426 (6th Cir. 1989)	7
Member Services Life Ins. Co. v. American National Bank and Trust Co. of Sapulpa, 130 F.3d 950 (10th Cir. 1997)	11
Mertens v. Hewitt Associates, 508 U.S. 248 (1998)	9, 13
Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985)	*passim*
Nachwalter v. Christie, 805 F.2d 956 (11th Cir. 1986)	11
Nazay v. Miller, 949 F.2d 1323 (3d Cir. 1991)	20
New York State Conf. of Blue Shield-Blue Cross Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)	8, 9, 17, 21, 26
Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)	*passim*
Pohl v. National Benefits Consultants, Inc., 956 F.2d 126 (7th Cir. 1992)	10, 11
Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983)	9
Smith v. Jefferson Pilot Life Ins. Co., 14 F.3d 562 (11th Cir.), *cert. denied*, 513 U.S. 808 (1994)	11
Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105 (5th Cir. 1993)	5, 6
Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982)	19, 20
Varsic v. United States, Dist. Ct., 607 F.2d 245 (9th Cir. 1979)	23
Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1276 (9th Cir. 1998)	8
Williams v. UNUM Life Ins. Co., 113 F.3d 1108 (9th Cir. 1997)	8

TABLE OF AUTHORITIES—Continued

STATUTES AND REGULATIONS

	Page
15 U.S.C. § 1012(b)	4, 5, 6
28 U.S.C. § 1254(1)	1
29 U.S.C. § 185	13, 15
29 U.S.C. § 1001(a), (b)	17, 29
29 U.S.C. § 1002(1)	17
29 U.S.C. § 1002(16)(A), (B)	2
29 U.S.C. § 1022(b)	18
29 U.S.C. § 1023(a)(2)	18
29 U.S.C. § 1101(b)(2)	18
29 U.S.C. § 1102(a), (b)	10
29 U.S.C. § 1104(a)(1)(D)	5, 10
29 U.S.C. § 1132(a)(1)(B)	5, 13
29 U.S.C. § 1133	2, 9, 15
29 U.S.C. § 1144(a)	4, 9, 10, 14
29 U.S.C. § 1144(b)(2)(A)	4, 11, 18
29 U.S.C. § 1144(b)(2)(B)	18
29 C.F.R. § 2560.503-1(d)	12
29 C.F.R. § 2560.503.1(c)-(g)	16
29 C.F.R. § 2560.503-1(g)(2)	16

MISCELLANEOUS

Administration of the Employee Retirement Income Security Act, Report of the Secretary of Labor to Congress (1987)	23
13A George J. Couch, *et al., Couch Cyclopedia of Insurance Law* § 49.49 at 276-77 (2d ed. 1982)	25
David L. Bacon, *et al., Employee Benefits Guide* § 8.02[1] Matthew Bender & Co. (1997)	21
Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, Report 1997	23
Statistical Abstract of The United States, p. 120 (117 ed. 1997)	23
H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) 2 Legislative History of the Employee Retirement Income Security Act at 2359	10

PETITION FOR A WRIT OF CERTIORARI

Petitioner, UNUM Life Insurance Company of America ("UNUM"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 134 F.3d 939 (9th Cir. 1998), and is reprinted in the Appendix ("App.") at 1a to 15a. The District Court's opinion granting summary judgment to UNUM (App. 16a to 19a) is unreported.

JURISDICTION

The Court of Appeals' judgment was entered on January 20, 1998. Justice O'Connor extended the time to file this petition to and including May 20, 1998 (App. at 16a). This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The statutes and regulations involved in this case are set forth at App. 47a-53a.

STATEMENT OF THE CASE

A. Factual Background

In February of 1988, UNUM issued a group long-term disability insurance policy to fund an employee welfare benefit plan (the "Plan") sponsored by Hajoca Corporation, an employer with multi-state operations for which respondent Michelle Cisneros worked. App. at 27a to 31a, 32a, 42a to 43a. The Plan is covered by the Employee Retirement Income Security Act ("ERISA"). App. at 2a. While the employer-sponsor served as plan administrator,[1] UNUM performed not only the Plan's initial claims-handling and payment functions, but also the fiduci-

[1] ERISA § 3(16)(A), (B), 29 U.S.C. § 1002(16)(A), (B).

ary review procedure for denied claims required by ERISA.[2] App. at 35a to 36a, 40a to 41a.

Cisneros, an office manager in California, was a participant in the Plan since its inception in 1988. She allegedly became totally disabled on June 2, 1992, due to a back injury. She did not submit a claim for plan benefits, however, until approximately April 20, 1994. UNUM received the claim on April 22, 1994, two years after her claimed back injury. Prior to receipt, it did not know she claimed to be "disabled."

The Plan's written notice and proof of claim provisions required a participant to submit to UNUM a written notice of claim for plan benefits within 30 days of the date disability starts, if possible, and a written proof of claim, at the latest, one year and 180 days after the onset of disability. App. at 29a, 4a, 19a, 40a to 41a. Cisneros' notice of claim was untimely by nearly 15 months, and her written proof of claim was submitted five months after the Plan's last deadline. App. at 19a, 40a to 41a. Accordingly, no benefits were "due" under the Plan's written terms.

After reviewing Cisneros' claim for plan benefits and supporting materials, UNUM determined that she was ineligible because she did not submit her claim within the Plan's written time limits. UNUM notified her of its decision in April of 1994; she, in turn, requested a review. App. at 37a to 39a. In the ERISA-required fiduciary review procedure for denied claims, UNUM upheld the decision to deny plan benefits. App. at 40a to 41a.

B. The Complaint

On March 1, 1995, Cisneros filed suit against UNUM in California state court to recover plan benefits as well as attorney's fees and costs. App. at 42a to 46a. She

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[2] ERISA § 503, 29 U.S.C. § 1133.

alleged that she had worked for her employer since 1984, but that the employer had not advised her of the Plan. She further alleged that she filed a benefit claim in the Spring of 1994, when she finally learned of the Plan. App. at 43a to 44a.

In May of 1995, UNUM removed the action to the United States District Court for the Southern District of California. App. at 18a.

C. The District Court's Decision

UNUM moved, under Rule 12(b)(6), to dismiss the complaint because of Cisneros' untimely claim. The District Court treated UNUM's motion as one for summary judgment, and granted it under ERISA on June 22, 1995. The District Court held that the Plan's written proof of claim provision was unambiguous, that it required proof of claim be filed within one year and 180 days after the onset of disability, and that Cisneros failed to comply with this provision. App. at 17a to 20a.

Additionally, the District Court rejected Cisneros' argument that California's common-law "notice-prejudice" rule survived ERISA preemption. If applicable, this rule would preclude UNUM—the claims review fiduciary—from upholding the claim denial unless it could establish "actual prejudice" from the failure to comply with the proof of claim provision. The Court stated that if Cisneros had any claim, it was against her employer. App. at 23a. Cisneros appealed.

D. The Ninth Circuit's Decision

On appeal of the summary judgment, the Ninth Circuit reversed the decision of the District Court. It agreed that Cisneros failed to satisfy the Plan's unambiguous written proof of claim provision and also agreed that California's common-law "notice-prejudice" rule was within the scope of ERISA preemption as a state law which "re-

lated to" an employee benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). It held, however, that the rule was "saved" from ERISA's preemption because it was a state law regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and therefore should be applied to Cisneros' claim for plan benefits. App. at 2a, 8a to 13a.

The Ninth Circuit stated that under *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987), ERISA's "saving" clause may be applicable only if the state law clears two hurdles: a common-sense test that the law be "specifically directed" at the insurance industry, and the "saving" clause requirement that the law must "regulate insurance." To determine whether the state law regulated insurance, the Court analyzed whether it satisfies the three McCarran-Ferguson Act criteria for the "*business of insurance*." App. at 8a, 10a to 12a. Under these criteria as articulated by the Supreme Court, the state law must first have the effect of transferring or spreading the policyholder's risk of loss to the insurer, "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-212 (1979). Second, the state law must be an integral part of the insurance policy relationship between insurer and insured. Third, it must be limited to entities within the insurance industry. *Metropolitan Life*, 471 U.S. at 743; *Pilot Life*, 481 U.S. at 48-50. Additionally, to avoid a conflicts-preemption bar, the state law—even if it otherwise satisfies the "saving" clause—must not conflict with one of ERISA's substantive provisions, including its exclusive civil enforcement scheme. *Pilot Life*, 481 U.S. at 51-57.

The Ninth Circuit found that California's common-law "notice-prejudice" rule did *not* transfer or spread the policyholder's risk of loss to the insurer, and thus failed to satisfy the first McCarran-Ferguson criterion. Finding that the rule satisfied the last two criteria, the Court then

held that ERISA's "saving" clause would preserve a state common-law rule even though it did *not* satisfy all three criteria. App. at 10a to 13a.

The Ninth Circuit expressly *acknowledged* that its ERISA "saving" clause holding that all three McCarran-Ferguson criteria were not essential conflicted with two Fifth Circuit decisions, *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996), and *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993). It stated: "we recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied . . . We . . . disagree." App. at 11a to 12a.

The Ninth Circuit also rejected UNUM's arguments, based on *Pilot Life*, 481 U.S. at 51-57, that the "notice-prejudice" rule should nevertheless be barred under conflicts-preemption because it conflicted with a number of ERISA's key substantive provisions and destroyed the uniformity of law that Congress intended to govern plan administration. UNUM had pointed out that the rule would require the payment of benefits under circumstances where payment is barred not only by ERISA's fiduciary responsibility provisions requiring plans to be administered "in accordance with" their written terms, but also by its exclusive civil enforcement scheme allowing suit for benefits only if "due" under those terms. ERISA §§ 404(a)(1)(D), 502(a)(1)(B), 29 U.S.C. §§ 1104(a)(1)(D), 1132(a)(1)(B). The Ninth Circuit acknowledged a direct conflict between the rule and ERISA, conceding that the rule caused "*a plan's written terms* [*to be*] *altered*," caused "*complications and extra burdens*" on plan administration, and made the plan "*more difficult to administer*." Further, it acknowledged that the rule "*differ*[*ed*] *markedly*" in various states. App. at 13a to 14a (emphasis added). Nonetheless, the Court rejected UNUM's preemption arguments.

REASONS FOR GRANTING THE WRIT

I. THE NINTH CIRCUIT'S ERISA PREEMPTION DECISION CONFLICTS DIRECTLY WITH HOLDINGS IN THE THIRD, FIFTH, SEVENTH, EIGHTH, TENTH AND ELEVENTH CIRCUITS.

Once again the Ninth Circuit has brought itself sharply into conflict with other Circuits on important federal issues which require uniformity nationwide. The ERISA preemption decision creates an acknowledged, direct conflict among holdings in the Circuits which only this Court can resolve. The Ninth Circuit's holding has engendered a similar holding in the Sixth Circuit but squarely conflicts with the holdings of the Fifth Circuit, which require a state law to satisfy *all three* of the McCarran-Ferguson Act factors for the "business of insurance" in order to be "saved" from ERISA preemption. *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993). The decision below expressly acknowledged this direct conflict. App. at 11a to 12a. Indeed, the conflict is even more widespread as shown by the observation in *Tingle* that "[t]he Eleventh, Sixth, Tenth and Eighth Circuits have all held that a statute's failure to satisfy one or more of the *Metropolitan Life* factors excludes it from the ERISA saving insurance clause." 996 F.3d at 110. Most recently in *Davies v. Centennial Life Ins. Co.*, 128 F.3d 34, 940 (6th Cir. 1997), the Sixth Circuit acknowledged the widening Circuit conflict as to whether all three McCarran-Ferguson factors are required, holding that "no single one is dispositive." It cited the decision below on that point and provided a *but see* reference to the Fifth Circuit's *CIGNA* decision.

The Ninth Circuit's holding that the "saving" clause does not require satisfaction of the first prong of the McCarran-Ferguson test—the actual spreading or transfer of the risk of loss—further conflicts with the holdings of the Third, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits, all of which uniformly have ruled that state

laws which fail to spread or transfer an insurance policyholder's risk, an "indispensable characteristic of insurance," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-213 (1979), are not saved from preemption by ERISA § 514(b)(2)(A). *Insurance Bd. v. Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (state law which fails to transfer risk or satisfy any other McCarran-Ferguson Act factor is preempted); *Tingle*, 996 F.2d at 108 (state law which fails to transfer risk is preempted); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 428-430 (6th Cir. 1989) (state law which fails to transfer risk or satisfy third factor is preempted); *DeBruyne v. Equitable Life Assur. Soc.*, 920 F.2d 457, 468-470 (7th Cir. 1990) (same); *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-154 (8th Cir. 1990) (state law which fails to transfer risk is preempted), *cert. denied*, 501 U.S. 1238 (1991); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 455-456 (10th Cir. 1989) (state law which fails to transfer risk or satisfy second factor is preempted); *Anschultz v. Connecticut Gen'l Life Ins. Co.*, 850 F.2d 1467, 1468-1469 (11th Cir. 1988) (same).[3]

The Ninth Circuit's preemption decision not only destroys the national uniformity of law in plan administration that is one of ERISA's chief goals, but also causes a Circuit split that is certain to widen in the future and encompass additional state law rules. This Court need look no further than two companion cases involving petitioner UNUM

[3] In fact, the Ninth Circuit's application of the McCarran-Ferguson factors in ERISA cases even differs from its own treatment of the same factors in non-ERISA cases. *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486, 1490 (9th Cir.), *cert. denied*, 510 U.S. 964 (1995) ("our own cases applying these [McCarran-Ferguson] factors also 'emphasize that the primary characteristic of the business of insurance is the transfer or spreading of risk'") (citation omitted) (RICO case). The *Cisneros* decision also conflicts in principle with earlier Ninth Circuit decisions holding that ERISA preempts state law rules of insurance contract interpretation because uniform federal law must control. *See, e.g., Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1440 (9th Cir. 1990).

for a sampling of what the Ninth Circuit has in store for ERISA preemption law and ERISA plan sponsors. *See Ward v. Management Analysis Co. Employee Disability Benefit Plan*, 35 F.3d 1276 (9th Cir. 1998) (ERISA does not preempt: (i) a state common-law doctrine which deems the employer-sponsor and administrator of a plan the "agent" of the insurer, and (ii) the same "notice-prejudice" rule at issue in the current proceeding); *Williams v. UNUM Life Ins. Co.*, 113 F.3d 1108, 113 (9th Cir. 1997) (California's "rolling accrual" proof of loss provision (each monthly failure to pay benefits constitutes a new cause of action) may void an ERISA plan's limitation of actions provision). The Ninth Circuit's reasoning in both of those cases is the same as its reasoning in the present case. Because of the significant consequences the Ninth and Sixth Circuits' new preemption holdings will have on insured ERISA plans, the undersigned counsel is filing a petition for a writ of certiorari concurrently in the *Ward* case.[4]

This acknowledged Circuit conflict on a significant ERISA preemption issue is alone sufficient ground for this Court's review.

II. THE NINTH CIRCUIT'S PREEMPTION DECISION CONFLICTS DIRECTLY WITH NINE OTHER CIRCUITS WHICH ENFORCE WRITTEN PLAN PROVISIONS SUCH AS NOTICE REQUIREMENTS.

Still another reason supports the granting of a writ of certiorari. In a direct clash with ERISA's plain language and decisions from nine other Circuits, the Ninth Circuit's decision will allow state common-law claims to *void* a number of the Act's key substantive provisions and prohibit written plan notice requirements permitted by ERISA. In so doing, it not only destroys ERISA's goals of a "'*uniform body of benefits law*'" and the "*nationally uniform administration*" of plans, *New York State Conf. of Blue Shield-Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995) (citation omitted) (emphasis

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[4] Respondent has been provided with a copy of the petition in the *Ward* case.

added) ("*Travelers*"), but also overlooks significant constraints which ERISA, this Court and the other Circuits have imposed on the adoption of state common-law principles in the employee benefit field.

ERISA is a " 'comprehensive and reticulated statute,' the product of a decade of congressional study of the nation's private employee benefit system." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) (citation omitted). ERISA was intended to encourage the growth and development of a purely voluntary system of self-funded and insured plans by providing an exclusive, uniform federal system of regulation including "*standards of conduct, responsibility, and obligation for fiduciaries.*" ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b) (emphasis added). One of ERISA's purposes is to avoid a "multiplicity of regulation," a " 'conflict in . . . law' " and " 'conflicting directives' " between federal and state regulatory systems. *Travelers*, 514 U.S. at 656-657. In striking a balance between competing federal and state interests, Congress made the administration of both insured and self-funded ERISA plans, including claims processing, " '*exclusively a federal concern.*' " *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (citation omitted) (emphasis added). Congress intended to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

To ensure uniformity of law, Congress enacted a broad array of national, uniform fiduciary standards to govern the administration of both self-funded and insured ERISA plans. ERISA §§ 401-414, 503, 29 U.S.C. §§ 1101-1114, 1133. Indeed, Congress had expressed strong concern that *insured* plans, because of the manner in which they were structured, generally had not been subject to the trust law principles it deemed essential to the adequate protection of the interests of plan participants and beneficiaries. Accordingly, Congress codified these federal "trust" principles, not only to ensure "*uniformity*," but also to ensure that certain "plans, such as insured plans, which

do not use the trust form as their mode of funding," would be subject to the same exacting standards. H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) 2 Legislative History of the Employee Retirement Income Security Act at 2359 (emphasis added).

Additionally, one "of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of the plan as written." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) (Posner, J.). ERISA's "written plan instrument" rule, one of ERISA's "core functional requirements," *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 78, 84 (1995), assists in ensuring the nationally uniform administration of plans. It requires that all plans—self funded and insured alike—be in writing and be administered by fiduciaries *"in accordance with"* their written terms to the extent not inconsistent with ERISA. ERISA §§ 401(a), (b), 404(a)(1)(D), 29 U.S.C. §§ 1102(a), (b), 1104(a)(1)(D) (emphasis added).[5] Moreover, ERISA's exclusive civil enforcement provisions ensure the same goal, authorizing suit for benefits *only* if "due" under those written terms. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *Pilot Life*, 481 U.S. at 52-57.

Apart from the Ninth Circuit, the Courts of Appeals have consistently carried forward ERISA's goal of a uniform national body of law governing plan administration by holding that the Act preempts state common-law "notice" rules or "notice" statutes. The rationale is that these state laws not only "relate to" ERISA plans, but also conflict either with the sponsor's freedom of plan design or the Act's exclusive regulatory scheme. *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1336-1337 (3d Cir. 1991) (ERISA preempts "notice-prejudice" rule with respect to self-

[5] The plan documents, which include the "contract or other instruments under which the plan is established or operated," encompass group insurance policies. ERISA § 104(a)(1), (b)(2); *see, e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987); *Roe v. General American Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983).

funded plan); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1157-1158 (2d Cir. 1990) (ERISA preempts state statute requiring a terminated employee be notified of insurance conversion option); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 571 (11th Cir.) (ERISA pre-empts state statute governing notice to insured of termination of coverage), *cert. denied*, 513 U.S. 808 (1994); *Doe v. Blue Cross & Blue Shield United*, 112 F.3d 869, 874-875 (7th Cir. 1997) (ERISA plan's internal limitation period controls over state statute).

Furthermore, the other Circuits have consistently held that ERISA precludes the use of any state or federal doctrines that would cause a departure from the plan's unambiguous written terms or any of ERISA's carefully-drawn statutory provisions which ensure uniformity of law in plan administration. *See, e.g., Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986) ("federal courts may not use state common law to rewrite a federal statute"); *Member Services Life Ins. Co. v. American Nat'l Bank and Trust Co.*, 130 F.3d 950, 957-958 (10th Cir. 1997) (courts cannot "rewrite [ERISA] to satisfy [their] procliviites"); *Pohl*, 56 F.2d at 128 (ERISA "confin[es] benefits to the terms of the plan as written"); *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888, 891 (11th Cir. 1997) ("[t]he cornerstone of an ERISA plan is the written instrument"); *Edwards v. Great-West Life Assur. Co.*, 20 F.3d 748, 750 (7th Cir.) (courts cannot "rewrit[e] the plan"), *cert. denied*, 515 U.S. 62 (194); *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486, 490 (1st Cir. 1989) (same); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 56, 59 (4th Cir. 1992) (same), *cert. denied*, 506 U.S. 1081 (1993); *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1005 (6th Cir. 1993) (same); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1295-1296 (5th Cir. 1989) (same).

The Ninth Circuit's decision not only directly conflicts with other Circuits but will spur additional litigation across the country as plan partcipants seek refuge in the

more generous provisions of state common law instead of pursuing their exclusive, uniform federal rights under ERISA. If one judicial revision of ERISA's text governing fiduciary duties and civil enforcement is appropriate through an artful and overly-expansive reading of the "saving" clause, plaintiffs and the lower courts will ask, why not two? If two, why not twenty or two hundred? This departure from the uniformity of law required by ERISA, the chaos in plan administration and the increased litigation and transaction costs will only lead plan sponsors to a reduction or elimination of employee benefits, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987), all in conflict with the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54.

The Ninth Circuit's decision also frustrates yet another principle central to ERISA's statutory scheme—the orderly internal resolution of benefit disputes as a prerequisite to filing suit under the Act's exclusive civil enforcement system. Notice of claim deadlines are standard features of many ERISA plans, protecting against the difficulties of proof, expenses and errors associated with stale claims.[6] A plan's written procedures and time limits for the filing of claims,[7] no less than the ERISA fiduciary review procedure required by § 503, are essential steps in the plan's administrative remedies.[8] A significant part of this Court's

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[6] *Central States, Southeast and Southwest Areas Pension Fund v. Mississippi Warehouse Corp.*, 853 F.Supp. 1053, 1058 (N.D. Ill. 1994); *Tiger v. AT&T Tech. Plan for Employees' Pensions, Disability Plan*, 633 F.Supp. 532, 534 (E.D. NY 1986).

[7] 29 C.F.R. § 2560.503-1(b), (c).

[8] *See Kinkead v. Southwestern Bell Sick & Acci. Corp. Disability Benefit Plan*, 111 F.3d 67, 68 (8th Cir. 1997); *Kennedy v. System One Holdings, Inc.*, 835 F.Supp. 947, 950 n.3 (S.D. Tex. 1993); *Christie v. K-Mart Corp. Employees Retirement Pension Plan*, 784 F.Supp. 796, 804 (D. Kan. 1992); *see also White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344, 346-47 (9th Cir. 1990) (plan's 60 day time limit for appealing denied claim is enforceable).

Pilot Life holding is that ERISA suits must be regarded as arising under federal law in a manner similar to those under § 301 of the Labor-Management Relations Act ("LMRA"), 481 U.S. at 55-56. Under § 301, an agreement's administrative remedies—including its written time limits for filing a claim—must be followed as a prerequisite to instituting these remedies and later to filing suit.[9] In permitting Cisneros' suit to proceed nonetheless, the decision below defers to the plaintiff but only at the cost of cutting across the grain of uniform federal law under ERISA, its antecedents in § 301 of the LMRA, and recent decisions by this Court.

ERISA "resolved innumerable disputes between powerful competing interests," but "not all in favor of potential plaintiffs." *Mertens v. Hewitt Associates*, 508 U.S. 248, 262 (1993). If, as this Court has stated, "[t]he authority of courts to develop a 'federal common law' under ERISA . . . is *not* the authority to revise the text of the statute," *id.* at 259 (citation omitted) (emphasis added), so, too, the federal courts cannot "save" state common-law rules in order to accomplish the same impermissible end. "[V]ague notions of a statute's 'basic purpose' "—*including* the "goal of 'promot[ing] the interests of employees and their beneficiaries in employee benefit plans' "—cannot be used to "overcome the words of its text regarding the *specific* issue under consideration." *Id.* at 261-262. Instead, a plaintiff must be able to point to a specific section of ERISA's civil enforcement provisions which "affirmatively *authorizes*" the relief sought, *id.* at 255 n. 5, a critical element that Cisneros admittedly cannot satisfy. The carefully-crafted nature of ERISA's statutory scheme precludes the Ninth Circuit's efforts to use state law to rewrite plan provisions and "fine tune" the statute in favor of plan participants. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147-148 (1985); *Pilot Life*, 481 U.S. at 54.

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[9] *See, e.g., Laws v. Calmat*, 852 F.2d 430, 434 (9th Cir. 1988); *Brazinski v. Amoco Petroleum Additives Co.*, 6 F.3d 1176, 1179 (7th Cir. 1993); *Vaca v. Sipes*, 386 U.S. 171, 184-85 (1967).

III. THE NINTH CIRCUIT'S PREEMPTION DECISION IS AN ATTEMPT TO CIRCUMVENT THIS COURT'S CONTROLLING *PILOT LIFE* DECISION.

The holding and reasoning of this Court's unanimous decision in *Pilot Life* also preclude the Ninth Circuit's holding that in a suit to recover plan benefits the "notice-prejudice" rule escapes ERISA preemption.

Pilot Life held that ERISA preempts state law causes of action alleging an insurance company's "improper processing of a claim" and failure to pay plan benefits. It held that these causes of action "related to" the plan and were not preserved by the "saving" clause. Additionally, it held that ERISA would bar these causes of action—even if the clause were applicable—because of a conflict with one of ERISA's substantive provisions, its exclusive, carefully-limited civil enforcement scheme in § 502(a). 481 U.S. at 51-57. In the present case, the Ninth Circuit concluded that Cisneros' "failure to submit timely proof of her claim does not necessarily invalidate her claim" under § 502(a)(1)(B) "to recover benefits due . . . under the terms of [the] plan" because the Plan must be read *as modified by California's "notice-prejudice" rule.* App. at 7a. The decision thus permits the identical result authorized by the lower court in *Pilot Life* and reversed by this Court: a state common law purporting to govern the processing of claims allows recovery that is both unavailable under the plan and in conflict with ERISA's substantive provisions, here its sections governing fiduciary responsibility and civil enforcement.

The decision below contravenes not only the Court's holding in *Pilot Life* but also its reasoning. In *Pilot Life*, the Court first evaluated Mississippi's "law of bad faith" under the common-sense and McCarran-Ferguson Act tests, then ruled that "we are obligated in interpreting the saving clause to consider . . . [its] role . . . in ERISA as a whole." Because the plaintiff's "bad faith" claims sought remedies for improper claims processing, a subject already

addressed in ERISA's enforcement scheme, the Court reasoned that "our understanding of the 'saving' clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA section 502(a)." *Pilot Life*, 481 U.S. at 52. The Ninth Circuit completely failed to consider the "saving" clause in this broader context.

To determine legislative intent, this Court evaluated the structure, language and purposes of the statute. First, the Court observed that § 502 is one of three statutory sections aimed at enforcing ERISA; the other two are § 503, governing the processing of claims and the fiduciary review of denied claims, and § 501, which provides criminal penalties for certain violations. *Pilot Life*, 481 U.S. at 52-53. Second, the Court noted that the language of the statute does not provide for the extra-contractual damages and other remedies that the plaintiff was seeking against the insurance carrier. Rather,

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-plan participants . . . were free to obtain remedies . . . that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54. Third, the Court determined that Congress intended to model ERISA's civil enforcement provisions after § 301 of the LMRA which "preempts any 'state-law claim whose resolution is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract.'" *Id.* at 55 (citation omitted). Thus, Congress intended "that *all* suits . . . asserting improper processing of [ERISA] claims . . . be treated as federal questions governed by § 502(a)." *Id.* at 56 (emphasis added).

Cisneros' claim fails under this analysis because the "saving" clause is not applicable but, even if it were, the claim would be preempted due to a conflict with ERISA's fiduciary responsibility rules and its exclusive civil enforcement scheme. ERISA §§ 502 and 503 and 29 C.F.R. § 2560.503-1(c)-(g) contain detailed provisions governing the filing and processing of ERISA claims, the fiduciary review procedure for denied claims, and the filing of suits for relief when such remedies are exhausted. Section 503 requires "*every* employee benefit plan" to comply with benefit claims regulations issued by the Secretary of Labor (emphasis added). Those regulations, in turn, specify that a plan's claims procedure may provide for the filing of claims with an insurance company, and that "a claim is filed when the requirement of a reasonable claim filing procedure . . . have been met." 29 C.F.R. § 2560.503-1(c)-(d). Under ERISA's fiduciary review procedure for denied claims, "fiduciaries" include an insurance company, or a Blue Cross/Blue Shield organization, serving as claim review fiduciary. *Id.* at (g)(2). By statute, these fiduciaries must follow the plan's written terms. ERISA § 404(a)(1)(D). Correspondingly, a participant who exhausts those administrative procedures may only file suit to recover benefits due "under the *terms* of [the] plan." ERISA §502(a)(1)(B) (emphasis added). This exclusive structure of fiduciary responsibility and civil enforcement would be "completely undermined if ERISA-plan participants" such as Cisneros could obtain benefits contrary to the plan's written terms and ERISA's civil enforcement scheme. *Pilot Life*, 481 U.S. at 54. Accordingly, the *Pilot Life* analysis precludes the result reached by the Court below.

IV. THE NINTH CIRCUIT'S PREEMPTION DECISION COMPLETELY DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS.

The Ninth Circuit's decision should be reviewed not only because it creates significant conflicts among the Circuits on ERISA preemption and flouts this Court's *Pilot Life* decision, but also because it has a far-ranging impact which destroys ERISA's key objective of governing the administration of *both* self-funded and insured plans under an exclusive, uniform body of federal law. As this Court has noted, the "potential for conflict in substantive law" is "[*p*]*articularly disruptive*" under ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (emphasis added). The decision's severe repercussions—which will create a crazy quilt of conflicting plan rules across the land—warrant swift intervention by this Court.

In misconstruing the plain text of ERISA, the Ninth Circuit's decision produces a result—the "multiplicity of regulation"—exactly opposite to the fundamental purposes of ERISA. To require all ERISA plans to be administered the same way in each state, Congress carefully crafted each of the Act's major components. It framed the definition of employee benefit plans explicitly to include *all* plans whether established "through the purchase of insurance or otherwise." ERISA § 3(1), 29 U.S.C. §1002(1). Congress also inserted a "deliberately expansive" preemption provision designed to make the regulation of both self-funded and insured plans "'*exclusively a federal concern.*'" ERISA § 514(a). *Pilot Life*, 481 U.S. at 45-46 (citation omitted) (emphasis added).

The Ninth Circuit correctly held that the California common-law "notice-prejudice" rule "related to" the administration of an employee benefit plan within the meaning of ERISA's preemption clause. App. at 7a to 8a, 13a to 14a. *See, e.g., Pilot Life*, 481 U.S. at 47-48; *Travelers*, 514 U.S. at 657-658, 660 (ERISA preempts state laws

that "mandate[] employee benefit structures or their administration," "prohibit" what is "permitted" by federal law, "preclude uniform administrative practice" or provide "alternate enforcement mechanisms"). But in holding that the "notice-prejudice" rule was shielded by ERISA's "saving" clause, § 514(b)(2)(A), it plainly erred on numerous grounds all of which undercut Congress' goal of uniformity of law and warrant review by this Court.

To ensure that uniform federal law would govern plan administration, Congress not only added a broad ERISA preemption clause but also significantly limited the "saving" clause by the "deemer" clause. It precludes any plan from being "deemed" an "insurance company" or "engaged in the business of insurance." ERISA § 514 (b)(2)(B). This significant qualification to the "saving" clause—completely overlooked by the Ninth Circuit—reflects Congress' commitment to free the administration of insured plans from the possibility of state regulation through some artful or overly-broad construction of the insurance exception. The "deemer" clause makes explicit Congress' objective to achieve exclusive federal uniformity in plan administration by barring direct state regulation of plans irrespective of their funding mechanisms. When the "deemer" clause is thus read in conjunction with the Act's objective, it is clear that state regulation impacting plan administration and benefit payment—regulation which strikes at the very core of ERISA—would be preempted, notwithstanding that plan administration is conducted in part by an insurance company or a Blue Cross/Blue Shield organization.

In allowing state law to seize control over ERISA plan structure and administration, the Ninth Circuit principally cited *Metropolitan Life*, 471 U.S. at 744, also citing *Pilot Life*, 481 U.S. at 48-50. Neither decision supports the holding below. In *Metropolitan Life*, after looking to

analogous language in the McCarran-Ferguson Act, this Court interpreted ERISA's "saving" clause to encompass a state mandated-benefits statute which satisfied all three McCarran-Ferguson criteria and regulated the contents of a group insurance policy, an area left completely *unregulated* by ERISA. 471 U.S. at 774, 735. *Pilot Life* also noted that *Metropolitan Life* "did not involve a state law that conflicted with a substantive provision of ERISA." 481 U.S. at 57. In *Pilot Life, id.* at 51-52, the Court held that even if the 'saving" clause were otherwise applicable to state actions involving the processing or payment of claims, ERISA preemption still would bar the actions because that area is exclusively regulated by uniform federal law under ERISA. The *Metropolitan Life* decision emphasizes, moreover, ERISA's proscription against any *direct* state regulation of plan structure and administration. The Court concluded that while insured plans could be indirectly subject to state laws which govern only the insurance company, like the mandated-benefits statute, laws that directly regulate the plan's design or operation would be impermissible. Because state regulation conflicting with these crucial areas—even when directed toward an insurance company standing in the shoes of the plan administrator or trustees—would constitute such direct regulation, this activity must necessarily yield to federal law.

Unfortunately, in its haste to permit state law control in ERISA-regulated areas, the Ninth Circuit simply grasped upon one statement in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), that 'none of [the McCarran-Ferguson factors] is necessarily determinative," thereby concluding that the "notice-prejudice" rule could be "saved" from preemption even if it did not involve the transfer of risk of loss. A common-sense reading of *Royal Drug* and *Pireno* indicates exactly the opposite. The Ninth Circuit's decision overlooked the core of *Pireno's* McCarran-Ferguson analysis including its earlier citation, with approval, to *Royal Drug's* statement that the transfer of risk is an " 'indispensable characteristic of

insurance.'" 458 U.S. at 127-28 and n.7. Read together, the two decisions reflect that while no one McCarran-Ferguson factor may bring a state law within the "business of insurance" requirement, *Pireno*, 458 U.S. at 129, no state law will be considered to regulate the "business of insurance" *unless* it involves the transfer of risk because that is "an *indispensable* characteristic of insurance." *Royal Drug*, 440 U.S. at 211-213 (emphasis added). *Pireno*, 458 U.S. at 127-128 and n.7. Further, neither decision had the occasion to address conflicts-preemption and the exclusivity of ERISA's civil enforcement provisions as did *Pilot Life*, 481 U.S. at 51-57.

The Ninth Circuit also concluded that state law could control ERISA plan structure and administration because the other two McCarran-Ferguson factors were supposedly triggered by the "notice-prejudice" rule—namely, the rule was an integral part of the insurance policy relationship, and was limited to entities within the insurance industry. This ruling conflicts in principle with two significant aspects of this Court's *Pilot Life* decision. Although identified with the insurance industry, the "notice-prejudice" rule has its roots in common-law contract rules of the broadest application which apply to *all* parties. These rules generally place a duty to cooperate on the parties, including a duty with respect to notices, and prevent a party from recovering if its breach has prejudiced the other party.[10] The late notice rule is merely a formulation of the common-law rule that a party's failure to comply with a contract's time limitation does not excuse the other

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[10] *See Restatement (2) of Contracts*, § 205, and Illustrations 3 (insurance company bound by duty to cooperate) and 9 (insurance policy notice and proof of loss provisions are subject to duty to cooperate), and *Restatement, Contracts*, §§ 315(1) and 395; *see also Campbell v. Allstate Life Ins. Co.*, 60 Cal.2d 303, 305 (1963) ("notice-prejudice" rule is based on a "cooperation" clause in insurance contract); *Hyndons v. Home Acc. Ins. Co.*, 214 Cal. 743, 746 (1932) (same). Under California law, this duty to cooperate exists "[i]n every contract." *Universal Sales Corp., Ltd. v. California Press Manufacturing Co.*, 20 Cal.2d 751, 771-72 (1942).

party's performance unless the limitation was a material part of the contract.[11] In light of its antecedents, the "notice-prejudice" rule no more constitutes a law "regulat-[ing] insurance" than any other common-law rule of general application such as rules regarding "ambiguity," or "unreasonableness," "adhesion contract" rules, or "bad faith" rules and extracontractual liability doctrines. The Ninth Circuit thus ignored *Pilot Life's* conclusion that although the state common-law breach of contract and insurance "bad faith" claims in that case were "identified with the insurance industry," ERISA preempted nonetheless because "the roots of this law are firmly planted in the general principles of [state] contract and tort law" and, moreover, conflicts-preemption would bar this claim even if the "saving" clause otherwise applied. 481 U.S. at 50-57.

"In essence . . . the McCarran-Ferguson Act permits the states to regulate insurance in such primary areas as licensing, underwriting, reserves, insurance policy content, and taxation, but does *not* permit state regulation in areas governed by ERISA such as plan administration, fiduciary liability, claims-handling and civil enforcement." David L. Bacon, *et al.*, *Employee Benefits Guide*, § 8.02[1] (Matthew Bender & Co.) (1997) (emphasis added). State law cannot "preclude uniform administrative practice." *Travelers*, 514 U.S. at 660. Any other construction of ERISA and McCarran-Ferguson would allow the destructive results produced by the Ninth Circuit's decision —state common-law rules of general application, not affecting the risk of loss, allowed to regulate plan structure

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[11] *Aetna Cas. and Surety Co. v. Murphy*, 206 Conn. 409, 538 A.2d 219 (1988) (justifying adoption of "notice-prejudice" rule on general contract principle of avoiding a disproportionate forfeiture); *Unigard Security Ins. Co. v. North River Ins. Co.*, 79 N.Y.2d 576, 594 N.E.2d 571 (N.Y. 1992) (prejudice requirement based on the general principle against interpreting a contractual duty as a condition precedent "absent clear language showing the parties intended to make it a condition"); *Restatement (2d) of Contracts*, § 229.

and administration, thereby destroying the uniformity of law required by ERISA. The decision not only flouts the ERISA preemption holding in *Pilot Life*; it has no basis in law or logic. "States are not free to change ERISA's structure and balance," even by *statute*. *Boggs v. Boggs*, 117 S.Ct. 1754, 1762 (1997).

The Ninth Circuit's decision thus overturns the plan sponsor's freedom of design and the uniform federal scheme for plan regulation which are ERISA's central axis. The court responded to this argument by noting that administrative difficulties caused by a multiplicity of state common law " 'are the inevitable result of the congressional decision to 'save' local regulation.' " App. at 9a to 10a (citation omitted). The state laws "saved" by Congress, however, were narrowly limited to those which caused the transfer of risk of loss, regulated the "business of insurance," and did not conflict with ERISA's substantive provisions. The Ninth Circuit cannot ignore the 'deemer" clause, expand the "saving" clause far beyond its traditional, well-recognized boundaries, disregard conflicts-preemption and, at the same time, excuse the resulting sharp conflict between federal and state regulation—the exact opposite of ERISA's goals—by claiming that such conflict is the will of Congress.

V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR ERISA PLANS THAT SHOULD BE ADDRESSED BY THIS COURT.

Unless corrected, the Ninth Circuit's ill-advised, revolutionary decision will not only impose a multiplicity of conflicting federal-state regulation, but also surrender significant portions of the administration of insured ERISA plans to the varying laws of the 50 states. This is the exact opposite of what Congress intended.

The Ninth Circuit's decision along with the Sixth Circuit's decision in *Davies*, 128 F.3d at 940—coupled with the Circuit conflicts over ERISA preemption—will also create enormous confusion and difficulty in the design and

administration of thousands of insured welfare plans across the country. Pension plans with insurance funding will face exactly the same difficulties. ERISA, unfortunately, does not limit the decisions' adverse effects to the Sixth or Ninth Circuits. The Act provides for nation-wide service of process, and permits a suit to be filed in any district where the plan is administered, the breach of fiduciary duty took place, or a defendant resides or may be found. ERISA § 502(e)(2); *see, e.g., Varsic v. United States Dist. Ct.*, 607 F.2d 245, 248 (9th Cir. 1979). As a result, the great majority of sponsors of insured plans coast to coast now are subject to the risk not only that the structure of their plans may be overturned, but also that the plan's administration and benefit payments may be subject to conflicting state laws pursuant to the Ninth Circuit's unprecedented standard for ERISA preemption and the Sixth Circuit's parallel decision.

The practical consequences of the Ninth and Sixth Circuits' decisions are staggering. Just in terms of major medical care plans alone, there are an estimated 4.5 million employer-sponsored plans [12] covering over 161 million individuals.[13] Overwhelming percentages of these plans either are insured, with a large subset being Blue Cross/Blue Shield plans, or are self-funded plans with stop-loss insurance.[14] More than 9 out of 10 such plans delegate some portion of ERISA claims-handling and payment—and the fiduciary review authority mandated by ERISA § 503—to insurance companies, Blue Cross/Blue Shield organizations or third-party administrators.[15]

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[12] ADMINISTRATION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, REPORT OF THE SECRETARY OF LABOR TO CONGRESS at i (1987).

[13] STATISTICAL ABSTRACT OF THE UNITED STATES, p. 120 (117 ed. 1997).

[14] MERCER/FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS, Report 1997, 17-18.

[15] *Id.* at 18.

Across the country, plan sponsors need to know whether they can design insured ERISA plans without fear that their written terms will be overturned in one state or another through an overly-expansive application of ERISA's "saving" clause. Depriving employers of the discretion over plan design will only provide a strong disincentive to establish such plans in the first instance. See, e.g., *Health v. Varity Corp.*, 71 F.3d 256, 258 (7th Cir. 1995).

The plan administrators and claims review fiduciaries for these plans, moreover, can be expected to process literally millions of ERISA claims for disability, pension and health benefits annually. Unless this Court resolves the Circuit conflicts, it will be impossible for administrators and fiduciaries to rely on a "uniform body of benefits law," or engage in the "nationally uniform" plan administration which was a "basic thrust" of ERISA. *Travelers*, 514 U.S. at 656-657. Further, they will be unable to administer their plans both in compliance with the plans' written terms and the Ninth Circuit's decision. The administrators and fiduciaries cannot know whether to deny a claim on the basis of a clear plan limit, or to accept the claim under state law without regard to the terms of their plan and thus breach an ERISA fiduciary duty. They cannot even know which opposing sets of federal and state laws to apply to determine those questions.

The Ninth and Sixth Circuits' decisions also will create an anomalous, confusing split between the administration of self-funded plans which would not be subject to common-law rules such as the "notice-prejudice" rule, insured plans which would be, and self-funded plans with stop-loss coverage which presumably would not be until an ERISA claim reached the stop-loss attachment point. Indeed, many plans include not only a number of benefits, some self-funded and some insured, but also a single time limit for filing all claims. Adding to this confusion, the "notice-prejudice" rule has been rejected by many states and varies considerably across the land. Many jurisdictions

consider a timely claim as a condition precedent to recovery and thus do *not* follow such a rule. Other states presume prejudice to the insurer and require the claimant to establish its absence; still other states—such as California—require the insurer to prove "actual prejudice." *See* 13A George J. Couch, et al., *Couch Cyclopedia of Insurance Law* § 49.49 at 276-77 (2d ed. 1982). All of this uncertainty will create strong financial incentives for employers either to cut back or eliminate insured benefits altogether, or to use self-funded plans notwithstanding the greater stability and solvency of insured plans.

Furthermore, because it lacks a baseline in the transfer of risk of loss, an "indispensable characteristic of insurance," *Royal Drug*, 440 U.S. at 211-12, and disregards conflicts-preemption, the Ninth Circuit's new standard for construing ERISA's "saving" clause is so indeterminate that it will arguably include virtually any common-law rule of general application that can be identified with the insurance industry. The catch-all nature of this standard, coupled with the Ninth Circuit's readiness to overturn an ERISA plan's written terms, will permit the exact reverse of ERISA's main goals: an almost unlimited range of state laws will be allowed to usurp control over plan design, administration, and civil enforcement. The decision, moreover, will resurrect the same obstacles to plan growth and development—the "multiplicity of regulation" and " 'conflicting directives' "—that the Act was designed to eliminate. *Travelers*, 514 U.S. at 657-657 (citation omitted).

The Ninth Circuit acknowledged the direct conflict between the "notice-prejudice" rule and ERISA, stating that the rule not only made the plan "*more difficult to administer*," but also caused "a plan's written terms [to be] *altered*." App. at 15a (emphasis added). The decision thus presents a "*direct clash* between state law and the provisions and objectives of ERISA," one where preemption necessarily arises because " 'compliance with both federal and state regulations is a *physical impossibility*.' "

Boggs v. Boggs, 117 S. Ct. 1754, 1762 (1997) (citation omitted) (emphasis added). To allow a state law rule not only to encroach on ERISA's exclusive framework for fiduciary standards and plan administration—but to "alter" the plan's written terms, and to permit a suit for benefits contrary to those terms—completely undermines a number of ERISA's most significant and highly-regulated areas. It also wreaks havoc on the principle of uniformity of law upon which ERISA is based.

Intervention by the Court is critical to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme. ERISA plans are not only "affected with a national public interest," § 2(a), 29 U.S.C. § 1001(a), but the appropriate balance between competing federal and state law is of paramount concern to the nation's employee benefit plan system. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S. Ct. at 1760, it is vital that this Court decide the significant, far-reaching ERISA preemption issue presented by this case, and resolve the existing Circuit conflicts.

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

Respectfully submitted,

Of Counsel:
TAMARRA T. RENNICK
Litigation Counsel
UNUM LIFE INSURANCE
COMPANY OF AMERICA
2211 Congress Street
Portland, ME 04122
(207) 770-2211

LESLEY C. GREEN
RUSSELL G. PETTI
BANNAN, GREEN &
FRANK LLP
555 South Flower Street
44th Floor
Los Angeles, CA 90017
(213) 362-1177

May 20, 1998

DAVID L. BACON
Counsel of Record
BENJAMIN I. DELANCY
CHARLES M. DYKE
THELEN, MARRIN, JOHNSON
& BRIDGES LLP
333 South Grand Avenue
34th Floor
Los Angeles, CA 90071
(213) 621-9800

Attorneys for Petitioner
UNUM Life Insurance
Company of America

APPENDIX

APPENDIX TABLE OF CONTENTS

	Page
Opinion of the Court of Appeals, filed January 20, 1998	1a
Notification by Supreme Court Clerk that time to File Petition Was Extended by Justice O'Connor to May 20, 1998	16a
Order of the District Court granting Summary Judgment, filed June 22, 1995	17a
Reporter's Transcript of Proceedings Before District Court, June 19, 1995	21a
Declaration of Donald F. Jensen And Portions of Exhibits In Support of Motion to Dismiss Complaint, filed April 25, 1995	25a
State Court Complaint, filed March 1, 1995	42a
ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b)	47a
ERISA § 3(1), (16), 29 U.S.C. § 1002(1), (16)	48a
ERISA § 402(a), (b), 29 U.S.C. § 1102(a), (b)	49a
ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D)	50a
ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)	51a
ERISA § 503, 29 U.S.C. § 1133	51a
ERISA § 514(a), (b)(2)(A), (B), (d), 29 U.S.C. § 1144(a), (b)(2)(A), (B), (d)	51a-52a
15 U.S.C. § 1012(b)	53a
29 C.F.R. § 2560.503-1(b), (c), (d), (g)	54a

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 95-56179

D.C. No. CV-95-00503-NAJ

MICHELLE CISNEROS,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA
and 1 through 50, Inclusive,
Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of California
Napoleon A. Jones, District Judge, Presiding

Argued and Submitted
January 9, 1997—Pasadena, California

Opinion Filed May 30, 1997
Opinion Withdrawn January 20, 1998

Filed January 20, 1998

ORDER AND OPINION

Before: Betty B. Fletcher and Stephen S. Trott, Circuit Judges, and Bruce S. Jenkins,* Senior District Judge

Opinion by Judge Trott

ORDER

The Opinion filed May 30, 1997, and published at 115 F.3d 669 is ordered withdrawn.

OPINION

TROTT, Circuit Judge:

OVERVIEW

Michelle Cisneros brought this action to recover long-term disability benefits under an ERISA-governed insurance policy (the "Policy") issued by UNUM Life Insurance Company ("UNUM"). The district court entered summary judgment in favor of UNUM on the ground that Cisneros's proof-of-claim was untimely under the Policy terms. We agree with the district court's conclusion that Cisneros failed to comply with the Policy's unambiguous time-limits for submitting proof-of-claim. However, because we hold that UNUM is required under a California law regulating insurance to show actual prejudice from Cisneros's untimely submission of proof in order to deny payment, we reverse the judgment in favor of UNUM and remand the case for further proceedings.

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* The Honorable Bruce S. Jenkins, Senior District Judge for the District of Utah, sitting by designation.

BACKGROUND

In 1988, Cisneros worked as an office manager at the Keenan Supply Company, a division of the Hajoca Corporation ("Hajoca"). On August 18, 1988, Cisneros suffered a work-related back injury. As a result of this injury, she has been continuously disabled since June 1992. In March 1994, Cisneros learned that Hajoca provided long-term disability insurance benefits under the Policy and mailed a benefit application to UNUM. Prior to this time, she allegedly was unaware that such benefits were available. UNUM acknowledged receipt of the claim on April 26, 1994, nearly two years after the onset of Cisneros's continuous disability.

UNUM denied Cisneros's claim because she had not complied with the proof-of-claim requirements in the Policy which, according to UNUM, required Cisneros to submit proof of her disability within one year and 180 days of the onset of her disability. Cisneros filed suit in California state court. UNUM removed the case to federal court and moved to dismiss for failure to state a claim. The district court treated the motion as one for summary judgment pursuant to Federal Rule of Civil Procedure 12(c) and entered summary judgment in favor of UNUM, ruling that Cisneros's application was untimely under the Policy terms.

STANDARD OF REVIEW

We review a grant of summary judgment de novo. *Bagdadi v. Nazar*, 84 F.3d 1194, 1197 (9th Cir. 1996). Whether ERISA preempts state law is a question of law, which we review de novo. *Inland Empire Chapter of Assoc. Gen. Contractors v. Dear*, 77 F.3d 296, 299 (9th Cir. 1996). The district court's determination of whether the Policy language is ambiguous is reviewed de novo. *See O'Neill v. United States*, 50 F.3d 677, 682 (9th Cir.), *cert. denied*, 116 S. Ct. 672 (1995). Finally, we review

the district court's interpretation of the Policy language de novo.[1] *Id.*

DISCUSSION

I. The Policy's Proof-of-Claim Provisions

The district court concluded that the Policy's proof-of-claim provisions were unambiguous and that they required Cisneros to submit proof of her claim, at the latest, within one year and 180 days after the onset of her disability. We agree. Section VI.F. of the Policy states:

> 2. Proof
>
> a. Proof of claim must be given to the Company. This must be done *no later than 90 days after the end of the elimination period.*
>
> b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. *But proof of claim may not be given later than one year after the time proof is otherwise required.*

(Emphasis added). The Policy defines the "elimination period" as the ninety-day period following the onset of the insured's disability.

As we interpret this language, section VI.F.2.a. of the Policy required Cisneros to submit proof of her disability to UNUM ninety days after the elimination period (i.e., 180 days after her disability began). If it was not reasonably possible for her to submit proof within this time

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[1] UNUM urges us to adopt the Fifth Circuit's holding in *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552 (5th Cir. 1991), and to review the plan administrator's factual determinations regarding the timeliness of Cisneros's application under an abuse of discretion standard rather than a de novo standard. We decline to reach this issue, however, because no factual determinations are contested in this case.

frame, then section VI.F.2.b. of the Policy required Cisneros to submit proof of her disability, at the latest, one year later (i.e., a total of one year and 180 days after the onset of her disability).

We reject Cisneros's argument that this policy language is ambiguous. The language cannot reasonably be construed to mean that proof must be submitted whenever it is reasonably possible for the applicant to give proof. We also reject Cisneros's contention that the Policy failed to provide expressly for forfeiture of benefits in the event of untimely submission of proof. Section VI.F.2.b. provides that proof *"may not be given"* after one year and 180 days. Section VI.I. provides that benefits will be paid *"[w]hen the company receives proof."* (Emphasis added). Read together, these provisions logically and unambiguously establish that, under the Policy, timely submission of proof is a condition precedent to payment of benefits.[2]

Cisneros contends that it was not reasonably possible for her to submit proof until March 1994, nearly two years after her disability began, because that is when she learned of the Policy's existence. Even if we accept this contention as true, as we must, Cisneros still failed to comply with section VI.F.2.b., because she did not submit proof of her disability until well after the cutoff of one year and 180 days after the onset of disability. Therefore, the district court correctly concluded that Cisneros failed to comply with the Policy's proof-of-claim requirements, and that, under the language of the Policy, this failure could result in a forfeiture of benefits.

Directing our attention to *Nikaido v. Centennial Life Insurance Co.*, 42 F.3d 557 (9th Cir. 1994), however,

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[2] Cisneros's suggestion that Hajoca's failure to inform her of the availability of disability benefits is a "clerical error or omission," which, under the Policy, will not "deprive an employee of insurance," also is without merit. If this provision were intended to apply to a failure to submit proof of claim, then the Policy's proof-of-claim provisions would be meaningless.

Cisneros argues that the Policy's proof-of-claim provisions require proof after each monthly period of disability, and thus that each monthly period begins a new time limit for submitting proof. As a result, Cisneros argues, she is at least entitled to benefits for the period beginning one year and 180 days prior to the month when she did submit proof of loss.

In *Nikaido,* we considered whether an employee's claim for disabilty benefits was barred by the statute of limitations. The applicable statute of limitations was three years from the time proof of loss was due. The proof of loss provisions in the contract adopted the terms of California Insurance Code section 10350.7 and required submission "within 90 days after the termination of the period *for which the Company is liable.*" *Id.* at 560 (emphasis added). We interpreted the language "period for which the company is liable" to refer to *each month* of disability. *Id.* Thus, we held that proof was due after each month of continuing disability and that a new cause of action with a new three-year statute of limitations period also began each month. *Id.*

The *Nikaido* holding was based on the particular contract language at issue in that case. It simply does not apply to the proof-of-loss provision in the UNUM policy, which involves different language. The UNUM contract requires submission of proof within one year and 180 days of *the onset of disability.* Thereafter, "[p]roof of continued disability and regular attendance of a physician must be given to [UNUM] within 30 days of the *request for proof.*" (Emphasis added). In other words, unlike the contract in *Nikaido,* the UNUM Policy language does not require the insured to submit proof for each period of continuing disability; it only requires the initial submission of proof and then requires the insured to provide further proof upon request.

Cisneros argues, however, that the proof-of-claim provision in the Policy contravenes California law and that the terms of California Insurance Code section 10350.7, as interpreted in *Nikaido,* must be read into the policy. Because Cisneros failed to raise this argument in the district court, the record is unclear as to whether the UNUM policy does in fact violate California law. *See* Cal. Ins. Code § 10350 (insurer may include substitute proof-of-loss language if approved by the commissioner). Accordingly, on remand, the district court shall consider the effect of section 10350.7, as interpreted in *Nikaido.* For this purpose, we direct the district court's attention to our related holding in *Williams v. UNUM,* No. 95-16796, slip op. at 5794-96 (May 20, 1997).

II. The Notice-Prejudice Rule

Under California law, Cisneros's failure to submit timely proof of her claim does not necessarily invalidate her claim to benefits. California's "notice-prejudice" rule prevents an insurance company from avoiding liability on the basis of untimely notice or submission of proof unless the company proves it has been substantially prejudiced by the delay. *Shell Oil Co. v. Winterhur Swiss Ins. Co.,* 15 Cal. Rptr. 2d 815, 845 (Cal. Ct. App. 1993); *see also Clemmer v. Hartford Ins. Co.,* 587 P.2d 1098, 1106-07 (Cal. 1978) (en banc). Prejudice is not presumed from the delay alone, *Shell Oil,* 15 Cal. Rptr. 2d at 845, and the insurer must show *actual* prejudice, not the mere possibility of prejudice, in order to avoid liability. *Id.*

UNUM argues that ERISA preempts the notice-prejudice rule in this case. As a general rule, ERISA supersedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).[3] ERISA's "saving clause," however, expressly

[3] The Supreme Court recently has narrowed the scope of ERISA's "related to" language, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 115 S. Ct. 1671, 1677 (1995)

exempts from preemption any state law "which regulates insurance." *Id.* § 1142(b)(2)(A). Because we conclude that the notice-prejudice rule falls within the saving clause, we hold that the notice-prejudice rule is exempt from preemption.

In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740-43 (1985), the Supreme Court used an eclectic approach to decide whether a state law mandating minimum health care benefits "regulates insurance" within the meaning of the saving clause. First, the Court determined whether that law fit a common-sense understanding of insurance regulation. *Id.* at 740-42. Deciding that it did, the court then checked its conclusion against three criteria taken from case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15:

> [*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Id. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)). Using this approach, the Supreme Court held that the statute in question "regulates

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(finding no preemption of state surcharges imposed on patients covered by a commercial insurer, but not on those insured by Blue Cross/Blue Shield, because the surcharges have only an indirect economic effect upon employee benefit plans). *Travelers* reversed an expansive interpretation of "relate to" and concluded that:

> If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . . But that, of course, would be to read Congress's words of limitation as mere sham and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.

Id. at 1677.

insurance" and thus is "saved" from ERISA preemption. *Id.* at 740-44.

In so doing, the court made four observations that inform our conclusion in this case.

First, ERISA's "two preemptive sections, while clear enough on their faces are not a model of legislative drafting, for while the general pre-emption clause broadly preempts state law, the savings clause *appears broadly to preserve* the states' lawmaking power over much of the same regulation." *Id.* at 739-40. (emphasis added).

Second, the court "presume[d] that Congress did not intend to pre-empt areas of traditional state regulation." *Id.* at 740. Here we note that at least twenty-five states currently follow some variation of the notice-prejudice rule, demonstrating its widespread acceptance. Barry R. Ostrafer & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 4.02(b)(5) (8th ed. 1995) (citing cases).

Third, the court said, "Nor is there any contrary case authority suggesting that laws regulating the terms of insurance contracts should not be understood as laws that regulate insurance." *Id.* at 744.

Finally, the court was fully aware of the lack of uniformity its holding would produce:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter. We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities however, are the in-

evitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

Application of the *Metropolitan Life* approach to Cisneros' case compels us to conclude that the notice-prejudice rule is a law which "regulates insurance" and thus falls within the saving clause. First, by requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, the notice-prejudice rule dictates the terms of the relationship between the insurer and insured and so seems, as a matter of common sense, to "regulate insurance." The rule is directed specifically at the insurance industry and is applicable only to insurance contracts. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) ("A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.").

Our conclusion holds up when measured against the McCarran-Ferguson factors. Although the notice-prejudice rule may not have the effect of transferring or spreading the policyholder's risk, we believe this imperfection is not dispositive. The Supreme Court has explained that the term "risk"—as used in this factor—refers to the risk of injury for which the insurance company contractually agreed to compensate the insured. *Union Labor Life*, 458 U.S. at 130. The notice-prejudice rule does shift the risk of lost coverage as a result of late submission of proof, but it does not alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability. In this regard, the notice-prejudice rule is different from the Massachusetts mandatory benefits law at issue in *Metropolitan Life*. That law altered the substantive scope of coverage that Massachusetts insurance companies contractually were obligated to

provide. Thus, unlike the statute in *Metropolitan Life*, the notice-prejudice rule does not spread the policyholder's risk within the meaning of the first McCarran-Ferguson factor. *See Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569 n.9 (11th Cir. 1994) ("[A]lthough a statute that prevents cancellation of a policy without notice arguably affects the transfer of risk, since it regulates the conditions under which the insurer must continue to bear risks for the insured, it does not alter the initial apportionment of risk among the parties at the inception of the contract."); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993) ("Although the statute [which bars recovery for misrepresentations on an insurance application only where there was an intent to deceive] does shift the burden of innocent misrepresentations (the legal risks) onto the insurer, it does not spread the risk of insurance (health) coverage for which the parties contracted.").

Nevertheless, the other two McCarran-Ferguson factors weigh heavily in favor of the conclusion that the notice-prejudice rule "regulates insurance." By requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, the notice-prejudice rule effectively creates a mandatory contract term. The rule dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship. *See Metropolitan Life*, 471 U.S. at 740.

The third McCarran-Ferguson factor also is satisfied because the notice-prejudice rule applies only to the insurance industry. *See id.* Thus, two of the three McCarran-Ferguson factors strongly support the conclusion that the notice-prejudice rule "regulates insurance" within the meaning of ERISA's saving clause.

We recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied for a law to "regulate insurance." *CIGNA Healthplan of La., Inc. v. State of La.*, 82 F.3d 642, 650 (5th Cir.

1996), *cert. denied*, 117 S. Ct. 387; *Tingle*, 996 F.2d at 108. We respectfully disagree. From our interpretation of *Metropolitan Life* and *Pilot Life*, we conclude that the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption. *See Metropolitan Life*, 471 U.S. at 743 (describing the McCarran-Ferguson factors only as "relevant" criteria); *Pilot Life*, 481 U.S. at 48 (describing the McCarran-Ferguson factors as considerations to be weighed). Indeed, in cases interpreting the McCarran-Ferguson Act—from which the factors were born—the Supreme Court has explicitly noted that "none of [the McCarran-Ferguson factors] is necessarily determinative." *Union Labor Life*, 458 U.S. at 129. In this case, the McCarran-Ferguson factors, on balance, weigh in favor of the conclusion that the notice-prejudice rule "regulates insurance."

Given *Met Life's* approach, we can find no sense in concluding that this particular state law does not regulate insurance when it so clearly does. If California's rule does not regulate insurance, what does it regulate? A rote application of the risk spreading factor would work unreasoned mischief against the broad purpose of the saving clause, eliminating California's notice-prejudice insurance rule from its reach. We fail to discern much difference on one hand between forcing minimum health care benefits into contracts that do not contain them and subjecting contracts to a notice-prejudice rule on the other—that is, if the question is whether one regulates insurance and the other does not. We find unconvincing the idea that Congress and ERISA would save and thereby enforce a state law mandating insurance companies to provide specified coverage whether purchased by the insured or not, yet pre-empt and thereby nullify a state law requiring an insurer to show actual prejudice from late notice before it refuses to pay benefits purchased by the insured. In this respect, the proof of the pudding's recipe is in the eating.

Because we conclude that both common sense and the McCarran-Ferguson factors strongly support on balance the conclusion that California's notice-prejudice rule "regulates insurance," we hold that the rule escapes ERISA preemption and applies to Cisneros's claim of its own force.

We are fully cognizant of the complications and extra burdens that the notice-prejudice rule imposes on insurers. UNUM forcefully brings these to our attention. In this limited respect, a plan's written terms are altered. Moreover, the notice-prejudice rule is more difficult to administer and provides less predictability than does the calendar. All of this, of course, may generate additional litigation. UNUM's concerns are real—but that does not alter the scope of the saving clause written into the law by Congress or the validity of the notice-prejudice rule adopted in California. Moreover, we presume that insurers structure their premiums and conduct their financial affairs around the principle that they may have to honor and pay for the coverage provided.

III. Federal Common Law

This holding, however, does not end our task, for Cisneros also urges us to adopt the notice-prejudice rule as a rule of federal common law. ERISA directs us "to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in ERISA, referring to and guided by principles of state law when appropriate, but governed by the federal policies at issue." *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1500 (9th Cir. 1984). We decline this invitation.

It would appear that the federal common law we are directed to formulate must follow from preemption, not from a conclusion that the law is saved from preemption. *See Misic v. Building Serv. Empl. Health*, 789 F.2d 1374,

1377 (9th Cir. 1986). Otherwise, laws from different states dealing with the same subject but with different results would end up in irrecconcilable conflict with each other. For example, it has been brought to our attention that some States' notice-prejudice rules differ markedly from California's, some States presuming that the insurer has been prejudiced by late notice. *See Reid v. Conn. Gen. Life Ins. Co.*, 17 F.3d 1092, 1098 n.3 (8th Cir. 1994). If California's notice-prejudice rule requiring the insurer to prove actual prejudice is saved from preemption, then so would the other States' rules—but those rules would be inconsistent with any California inspired federal common law we might adopt. Moreover, which state law would prevail would depend only on which came first to the courthouse in this context. Such a result is patently untenable.

IV. Proof of Actual Prejudice

Because we hold that, as a matter of California law, UNUM is required to prove actual prejudice as a result of Cisneros's delayed submission of proof, we reserve the district court's grant of summary judgment in favor of UNUM. There is a genuine issue of material fact as to whether UNUM suffered actual prejudice by virtue of the untimeliness. *See Select Ins. Co. v. Superior Court*, 276 Cal. Rptr. 598, 602 (1990) (question of prejudice is one of fact).

UNUM argues on appeal that it did suffer prejudice because it was denied the opportunity to conduct a contemporaneous medical evaluation. But "prejudice does not arise merely because a delayed or late notice has denied the insurance company the ability to contemporaneously investigate the claim or interview witnesses." *Shell Oil Co.*, 15 Cal. Rptr. 2d at 845 (quoting *Northwestern Title Sec. Co. v. Flack*, 85 Cal. Rptr.. 693, 697 (Cal. Ct. App. 1970)). UNUM must show that it has suffered *actual prejudice*, not that there is a mere possibility of prejudice.

Because the plan administrator and the district court both believed that the notice-prejudice rule did not apply to Cisneros's claim, neither the plan administrator nor the district court determined whether UNUM suffered prejudice. Accordingly, we remand the case to the district court with instructions to remand to the plan administrator for a factual determination as to whether UNUM suffered actual prejudice by virtue of the untimely submission of proof. *See Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 951 (9th Cir. 1993).[4]

CONCLUSION

We agree with the district court's conclusion that Cisneros failed to comply with the Policy's unambiguous requirement that the insured submit proof of claim within one year and 180 days following the onset of disability. However, we hold that California's notice-prejudice rule applies to Cisneros's claim as a law that "regulates insurance" and is therefore saved from ERISA preemption. As a result, a genuine issue of material fact exists as to whether UNUM suffered actual prejudice from Cisneros's untimely submission of proof. Accordingly, we reverse the judgment of the district court and remand the case with instructions to remand to the plan administrator for a finding as to actual prejudice and for further proceedings consistent with this opinion.

REVERSED and REMANDED.

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[4] We do not consider Cisneros's remaining claim on appeal that, because Hajoca allegedly is UNUM's agent under state law, Hajoca's failure to inform Cisneros of the availability of disability benefits should be imputed to UNUM and thereby prevent UNUM from relying on the untimeliness defense. Cisneros only made a passing reference to the idea that Hajoca is UNUM's agent in its opposition to UNUM's motion for summary judgment. It did not fully develop the argument that it now raises on appeal. Accordingly, we decline to review this claim. *See A-1 Ambulance Serv. Inc. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir. 1996).

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
Washington, DC 20543-0001

April 13, 1998

Mr. David L. Bacon
Thelen, Marrin, et al.
333 S. Grand Ave., 34th Floor
Los Angeles, CA 90071

Re: UNUM Life Insurance Company of America
v. Michelle Cisneros
Application No. A-766

Dear Mr. Bacon:

The application for an extension of time within which to file a petition for a writ of certiorari in the above-entitled case has been presented to Justice O'Connor, who on April 13, 1998, extended the time to and including May 20, 1998.

This letter has been sent to those designated on the attached notification list.

Sincerely,
WILLIAM K. SUTER
Clerk

By /s/ Jeffrey D. Atkins
JEFFREY D. ATKINS
Assistant Clerk

[Filed Jun. 22, 1995]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 95-0503-J (BTM)

MICHELLE CISNEROS,

Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, and DOES 1 through 50, Inclusive,

Defendants.

ORDER TREATING MOTION TO DISMISS AS MOTION FOR SUMMARY JUDGMENT; GRANTING SUMMARY JUDGMENT IN FAVOR OF DEFENDANT

This action is before the court on defendant Unum Life Insurance Company's (Unum) motion to dismiss this action. However, Unum has presented to the court evidence outside of the pleadings. Pursuant to the procedure set forth in Federal Rule of Civil Procedure 12(b), the court will treat this motion as a motion for summary judgment. The parties have been notified that the court is treating this motion as a motion for summary judgment and have given the opportunity to present all relevant material.

FACTUAL BACKGROUND

Plaintiff filed this action in Superior Court against Unum alleging that she was wrongfully denied coverage under a disability insurance policy. As part of her employ-

ment with Keenan Supply Company plaintiff was covered by a disability policy issued by Unum. Plaintiff became eligible for disability benefits in June 1992 because of a back injury but was not informed by her employer that she was covered by disability benefits as part of her employment. Plaintiff alleges that as a result she did not file a claim with Unum until April 1994, which was almost two years after her disability occurred. Unum denied the claim, stating that it was untimely. Plaintiff claims that the denial of the claim constitutes a breach of contract.

Because plaintiff's claim is related to an employee benefit welfare plan regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq. (ERISA), defendant removed this action to federal court based on ERISA preemption. The court agrees with defendant that this action is preempted by ERISA. Thus, the court will apply federal law developed to govern ERISA plans in deciding plaintiff's claim against defendant for breach of contract.

ANALYSIS

Unum argues that under the terms of the disability policy, plaintiff's claim was indeed untimely so that Unum did not breach its contract with plaintiff by denying coverage. In this case, because there is no express language in the policy giving the ERISA fiduciary or administrator the discretion to determine elgibility, the district court reviews de novo a determination of non-eligibility for ERISA benefits. *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948 (9th Cir. 1993).

After reviewing the evidence before the court, including the disability policy, declarations submitted by both parties, and Unum's letters to plaintiff denying coverage, the court holds that the undisputed facts indicate that Unum correctly denied benefits because Plaintiff's claim was untimely.

The evidence before the court indicates that plaintiff became disabled in June 1992 but did not file a claim for disability benefits until almost two years later in April 1994. Unum explained to plaintiff that it denied benefits because the policy expressly states that a proof of claim must be filed *no later than one year* after the time the proof is otherwise required. The proof of claim is "otherwise required" 180 days after the disability occurs. Despite plaintiff's arguments, there is nothing at all ambiguous about this provision. Thus, at most, Cisneros had one year and 180 days after June 1992 to file her proof of claim. She missed this deadline by five months, and her claim is barred by the terms of the policy.

Plaintiff claims that the reason she filed so late is that her employer did not inform her that she was covered by a disability policy. To prevail on her action under this theory, plaintiff would have to cite relevant federal law or persuasive state law holding that a strict time limit for claims under a disability policy is inoperable against an insurance company when an employer does not inform the employee of the existence of the policy. Plaintiff has cited no such case law. Plaintiff presents to the court one recent Ninth Circuit case which deals with the statute of limitations as applied to a "continuing loss" policy which requires a proof of claim to be submitted every month. *Nikaido v. The Centennial Life Ins. Co.*, 42 F.3d 557 (9th Cir. 1994). *Nikaido* is inapplicable here because the statute of limitations is not at issue, nor was Unum's policy a "continuing loss" policy.

Thus, the court holds that based on the undisputed evidence submitted to the court, Unum was within its rights under the disability policy to deny plaintiff's claim as untimely. Summary judgment will be entered in favor of defendant Unum.

IT IS SO ORDERED.

DATED: June 21, 1995 /s/ Napoleon A. Jones, Jr.
NAPOLEON A. JONES, JR.
United States District Judge

CC: Magistrate Judge Moskowitz

THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

No. 95-0503-J (BTM)—CIVIL

CISNEROS, *Plaintiff*,

versus

UNUM LIFE INSURANCE COMPANY OF AMERICA, *Defendant.*

MOTION HEARING

San Diego, California
June 19, 1995

REPORTER'S TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE NAPOLEON A. JONES, JR.,
WITHOUT A JURY

* * * *

[2] (Prior unrelated proceedings.)

THE CLERK: Number 14, 95-0503, Cisneros versus UNUM Life Insurance, on for defendant's motion for summary judgment.

MS. GRUETTNER: Good morning, Your Honor. Alison Gruettner on behalf of defendant and moving party.

MR. METZGER: Good morning, Your Honor. Jeffrey V. Metzger for the plaintiff Cisneros.

THE COURT: Good morning, sir.

The record should reflect that this matter is on calendar on defendant's motion for summary judgment. The rec-

ord should reflect that the court has received and considered the papers filed in support and in opposition thereto. This matter originally came on on a motion to dismiss pursuant to 12(b).

I believe parties were notified that this court would elect to handle this as a Rule 56 motion; that is, a summary judgment motion. If this court is in error, I will appreciate counsel so indicating.

You have both received notice?

MR. METZGER: We did, Your Honor, yes.

THE COURT: Is there anything additional?

Is there anything additional to add?

MS. GRUETTNER: Your Honor, Unum would like to emphasize that this is an ERISA action governed by ERISA and [3] that, under ERISA, the law is clear that a claims review of a fiduciary, in this case Unum, has a duty to strictly enforce and adhere to the terms of the planned document, which is exactly what Unum did in this case by denying plaintiff's untimely claim for benefits.

MR. METZGER: Your Honor, I filed a response to the reply. Has that—did that reach the court?

THE COURT: Yes.

MR. METZGER: And has that been considered—because a couple of cases—*Joyce* was the one that I wanted to emphasize.

Should I come to the microphone?

THE COURT: Certainly, sir. It's easier for the reporter.

MR. METZGER: Thank you.

The case *Joyce* is the one I wanted to emphasize. That was a case cited in the *Freeman* case that was cited by the defendant in its reply brief; and the court in that *Freeman* case, to the extent that it is good authority in this particular action, cited the *Joyce* case, distinguishes it from the *Freeman* case; but the fact is that the *Joyce* case is similar to the present case because it's the only case other than the present case that we are dealing with where

the insured did not know of the benefits; and in the *Joyce* case, which was similar factually, the court held that that did create a triable issue as to whether or not it was reasonably [4] possible for the beneficiery or, in this case, the insured to have acted.

Other than that, I will submit on the Court's decision unless the Court has any questions.

THE COURT: No, sir.

Did you desire to respond?

MS. GRUETTNER: Yes, Your Honor.

The *Joyce* case was a state court case decided under Minnesota law which the plaintiff in the *Freeman* case cited in its papers. The court was distinguishing that case.

(Pause.)

We have here an insured under a disability policy rather than a beneficiary under a life insurance policy; and ERISA applies in any event. That case is inapplicable.

THE COURT: Thank you, counsel.

Let me just indicate that, having reviewed the case cited by counsel, but certainly the papers, the moving papers, the papers in opposition—did you have something additional?

MR. METZGER: I am just trying to hear.

THE COURT: Considering everything that has been submitted, this court would agree, Ms. Gruettner, that this action is barred because plaintiff did not timely file their request.

It seems to this court that, if there was a cause of action based upon what has been stated in the papers, sir, it [5] should have been against the employer in light of the late filing.

You will have the court's order within five court days.

MS. GRUETTNER: Thank you, Your Honor.

MR. METZGER: Your Honor, may I inquire as to one issue in the case?

Assuming, the correctness of that position, what is the court's feeling about the *Nikito* case which created a new cause of action with each passing month, such that it's presumed that it wasn't—well, assuming there is a new cause of action with each passing month, thereon, when the claim was initially submitted, then, even if the court was correct, it would bar the ones before that.

Why not—why are the ones that are not since that time timely?

THE COURT: Very simply, sir, because it's not applicable to this case. There wasn't the ongoing monthly cause of action that was presented; but that will be in the court's analysis.

MR. METZGER: Thank you.

(Further Unrelated Proceedings.)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

Case No. 95 0503 J BTM

MICHELLE CISNEROS,
Plaintiff,

vs.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendants.

DECLARATION OF DONALD F. JENSEN IN SUPPORT OF MOTION TO DISMISS COMPLAINT

Donald F. Jensen declares:

1. I am an employee of UNUM Life Insurance Company of America ("UNUM"), the defendant herein. I am the Manager of the Quality Review Section of the Long Term Disability Benefits Division. I am personally familiar with the group disability policy and the plaintiff's claim, seeking benefits under the policy.

2. Attached hereto as Exhibit A is a true and correct copy of the Long Term Disability Policy No. 334765 issued by UNUM to Hajoca Corporation with all amendments. The policy has been in effect since 1988.

3. Attached hereto as Exhibit B is a true and correct copy of the claim for long term disability benefits by plaintiff which was originally received at UNUM on April 22, 1994, the claim consists of the "Employer's Report of Claim" and the "Attending Physician's Statement," both on UNUM printed forms. The reverse side of the APS

contains the "Employee's Report of Claim." These documents were sent with a letter from plaintiff's employer dated April 20, 1994.

4. Attached hereto as Exhibit C is a true and correct copy of the letter dated April 28, 1994 from UNUM to plaintiff, denying her claim for disability benefits.

5. Attached hereto as Exhibit D is a true and correct copy of the letter dated June 1, 1994 from plaintiff to UNUM.

6. Attached hereto as Exhibit E is a true and correct copy of the letter dated August 17, 1994 from UNUM to the plaintiff upholding the earlier denial of her claim for disability benefits.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Donald F. Jensen
DONALD F. JENSEN, Manager
Quality Review Section
Long Term Disability Benefits Division

COUNTY OF CUMBERLAND)
) ss.
STATE OF MAINE)

The above-named Donald F. Jensen, known personally to me, appeared and made oath that the foregoing statements are based on his own personal knowledge and are true to the best of his knowledge and belief.

/s/ Kathie L. Breton
Notary Public
My Commission Expires: 12/22/94

EXHIBIT A

Policyholder: HAJOCA CORPORATION

Policy Number: 334765

Policy Effective Date: February 1, 1988

Premium Due Dates: February 1 and the first day of each following month.

Governing Jurisdiction: PENNSYLVANIA

Policy Anniversary: February 1, 1989, and each following February 1.

GROUP LONG TERM DISABILITY INSURANCE POLICY NON PARTICIPATNG

UNUM Life Insurance Company of America (referred to as the Company) will pay the benefits provided in this policy. The Company makes this promise subject to all of this policy's provisions.

The policyholder should read the policy specifications carefully and contact the Company promptly with any questions.

This policy is delivered in and governed by the laws of the governing jurisdiction.

Signed for the Company at Portland, Maine on the policy effective date.

/s/ Kevin J. Tierney
Secretary

/s/ Jerry F. Orr, III
President

UNUM Life Insurance Company of America

This policy is divided into sections as follows:

Section I	POLICY SPECIFICATIONS
Section II	DEFINITIONS
Section III	ELIGIBILITY AND EFFECTIVE DATES
Section IV	BENEFITS
Section V	TERMINATION PROVISIONS
Section VI	GENERAL POLICY PROVISIONS
Section VII	PREMIUMS

This policy follows a number-letter sequence. It is not necessary that it include all numbers or letters in complete sequence to be correct.

SECTION VI—GENERAL POLICY PROVISIONS

* * * *

E. MISSTATEMENT OF FACTS

If relevant facts about any employee were not accurate:

1. a fair adjustment of premium will be made; and
2. the true facts will decide if and in what amount insurance is valid under this policy.

F. NOTICE AND PROOF OF CLAIM

1. Notice

   a. Written notice of claim must be given to the Company within 30 days of the date disability starts if that is possible. If that is not possible, the Company must be notified as soon as it is reasonably possible to do so.

   b. When the Company has the written notice of claim, the Company will send the insured its claim forms. If the forms are not received within 15 days after written notice of claim is sent, the insured can send the Company written proof of claim without waiting for the form.

2. Proof

   a. Proof of claim must be given to the Company. This must be done no later than 90 days after the end of the elimination period.

   b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.

c. Proof of continued disability and regular attendance of a physician must be given to the Company within 30 days of the request for the proof.

d. The proof must cover:

i. the date disability started;

ii. the cause of disabilty; and

iii. how serious the disability is.

G. EXAMINATION

The Company, at its own expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of a claim, examined by a physician or vocational expert of its choice. This right may be used as often as reasonably required.

H. LEGAL PROCEEDINGS

A claimant or the claimant's authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

I. TIME OF PAYMENT OF CLAIMS

When the Company receives proof of claim, benefits payable under this policy will be paid monthly during any period for which the Company is liable.

J. PAYMENT OF CLAIMS

All benefits are payable to the employee. But if a benefit is payable to an employee's estate, an employee who is a minor, or an employee who is not

competent, the Company has the right to pay up to $1,000 to any of the employee's relatives whom the Company considers entitled. If the Company pays benefits in good faith to a relative, the Company will not have to pay such benefits again.

K. WORKERS' OR WORKMEN'S COMPENSATION

This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

L. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

[Logo] *UNUM*

APPLICATION FOR GROUP LONG TERM DISABILITY INSURANCE

Name of Applicant: HAJOCA CORPORATION

Address: 127 Coulter Avenue, Ardmore, Pennsylvania 19003

applies to the UNUM Life Insurance Company of America, for group long term disability coverage.

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The Policy Specifications will be made a part of the policy along with a copy of this form.

Policy Effective Date January 1, 1988

Dated at Ardmore, PA.

HAJOCA CORPORATION
(Applicant)

on December 30, 1987

By /s/ William R. Mentz
Assistant Secretary
(Signature and Title)

/s/ Bayly Martin & Fay, Inc.
(Agent or Broker Signature)

/s/ [Illegible]
(Witness Signature)

[Logo] *UNUM*

APPLICATION FOR GROUP LONG TERM DISABILITY INSURANCE

Name of Applicant: HAJOCA CORPORATION

Address: 127 Coulter Avenue, Ardmore, PA 19003

applies to the UNUM Life Insurance Company of America, for group long term disability coverage.

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The Policy Specificaitons will be made a part of the policy along with a copy of this form.

Policy Effective Date February 1, 1988

Dated at Ardmore, PA. HAJOCA CORPORATION
(Applicant)

on January 29, 1988 By /s/ William R. Murtz
Assistant Secretary
(Signature and Title)

/s/ [Illegible]
(Agent or Broker Signature)

/s/ [Illegible]
(Witness Signature)

EXHIBIT B

[Logo]

HAJOCA CORPORATION
127 Coulter Avenue
Ardmore, PA 19003
(215) 649-1430

April 20, 1994

UNUM
Ms. Donna P. Zeh
Group LTD Claims
Mid Atlantic Regional Benefits
P.O. Box 2031
Tarrytown, NY 10591-9031

Ref: Michelle Cisneros
DOB 11-09-47
Policy #: 334765-001

Dear Donna:

Enclosed is a request for Long Term Disability benefits for Michelle R. Cisneros. Please process in the usual manner.

If you have any questions or require additional information. Please call me at the number listed below.

Sincerely,

/s/ Deborah M. Gilligan
DEBORAH M. GILLIGAN
Employee Benefits Coordinator

EXHIBIT C

[Logo] *UNUM*

UNUM Life Insurance Company of America
Mid Atlantic Regional Benefits
PO Box 2031
Tarrytown, NY 10591-9031
1-800-321-0751
Fax 914 524-5815

April 28, 1994

MICHELLE R. CISNEROS
12435 OLD POMERADO RD.
POWAY CA 92064

RE: Michelle R. Cisneros DOB: 11-09-1947
Claim Number: 4S32665592
Policy Number: 334765-001

Dear Ms. Cisneros:

We have completed our review of your application for benefits under the above policy.

We regret that we are unable to continue processing your application for benefits because it was not submitted within the time frame specified in the contract. Under the policy provisions regarding notice and proof of claim, the policy specifies the time period in which this proof must be submitted.

Based on a disability date of 06/06/92, your elimination period would have been satisfied 09/04/92. Your application for benefits was received on 04/26/94. As this is beyond the time frame indicated in the policy, we regret to advise you that we will not be able to give consideration to your application for benefits and are closing your claim file.

If you have new, additional information to support your request for disability benefits, please send it to me at the above address.

If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice to:

UNUM
LTD Quality Review Section
211 Congress Street
Portland, ME 04122-0306

Please be sure to include your Social Security and policy numbers. Your written request should include your comments and views of the issues, as well as any documentation you wish UNUM to consider. You may also request copies of pertinent documents contained in your file. If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

If you have any questions, please contact me at 1-800-321-0751.

Sincerely,

Donna Zeh
Sr. Disability Benefits Specialist
DZ/mfr

cc: Deborah M. Gilligan

June 1, 1994

EXHIBIT D

UNUM
LTD Quality Review Section
2211 Congress Street
Portland, ME. 04211-0306

RE: Michelle R. Cisneros DOB: 11-09-1947
Claim Number: 4S32665592
Policy Number: 334765-001

Dear UNUM:

I am writing this request for review of my application of benefits for LTD disability.

On August 10, 1988 I injured my back while at work. After notifying my employer, I sought treatment of a chiropractor, who took me out of work for approximately six weeks. I notified my employer by phone and with a letter from the doctor. My employer informed me that this was in our coverage by workers compensation and my medical expenses, plus temporary disability payments would be paid by our workers compensation carrier, Wausau until I was released to return to work. Unfortunately I was not able to return to work until August 16, 1989. I was never informed by my employer that I was also entitled to Long Term Disability as well as workers compensation.

Over the period of the next three years I was intermittently out of work for periods of three to six months due to reocurring problems with by back. All these times I was again informed that I would be covered by workers compensation, until I could return to work. On June 6, 1992 I again went out on workers compensation for disability of my back injury. Again the doctor suggested continuing conservative treatment, which consisted of therapy and epidural steroid injections to the lower back. These treatments, unlike before, were not successful. In

September of 1992, the doctor stated that the treatments were not as successful as before and we must consider surgery as our only option. This was confirmed by both the surgeon, Dr. R. Thorne and Dr. D. Ingram. I informed my employer about the surgery and that I would probably be out of work for at least ten to twelve months after surgery. Even at this time when my employer knew I would be out of work for that length of time I was never informed of my entitlement of LTD. On January 28, 1993, I had back surgery.

Unfortunately the surgery was not as successful as we had hoped. In January's appointment with Dr. Thorne, he told me that the left leg pain, tingling, numbness and left leg giving out without notice, was something that I was going to have to live with now. He stated he considered me disabled at this time and I would not be able to go back to work.

In March of 1994, a friend asked me if I was receiving long term disability from my employer. On March 16, 1994, I called Hajoca and asked if we had such a policy and if so could they send me information. Deborah M. Gilligan said yes we did have that coverage and she would send me the booklet and claim form that day. She sent me the application, 'but not the booklet', and instruction on what else I needed to send her after the application was completed.

On May 5, 1994 I received a letter from Donna Zeh of UNUM Insurance, along with a booklet entitled UNUM a Group Long Term Disability Insurance. In the letter it stated that they regretted that they were unable to process my application for benefits because it was not submitted within the time frame specified in the contract. At this time I still have not received the handbook from Hajoca on Long Term Disability. In the booklet that you sent me on LTD, the very first paragraph states and I quote, "Long term disability insurance is one of the most valuable—but least understood—of all employee benefits."

On May 8, 1994, after three request, I received the employees booklet on LTD. Prior to this I had no knowledge of the requirements for LTD.

At no period of time did I consider myself totally disabled until now. I fully thought I would be able to return to work after my surgery and recovery time, January, when Dr. Thorne stated as such.

Surely had I been informed of my eligibility for LTD, as I was informed of my eligibility for Worker's Compensation benefits, I would have applied at the proper time of my elimination period. I would also like to know since I had a certain period to apply for LTD, what is the period of time that my employer has to notify me of my eligibility for these benefits.

I sincerely hope you will reconsider my claim for Long Term Disability benefits, due to the lack of communication from my employer on these benefits.

If you should need any further information or records to support my request for disability benefits, I will send them upon your request.

Thank you for your reconsideration.

Sincerely,

/s/ Michelle Cisneros
MICHELLE CISNEROS

cc: Donna Zeh
Gilbert Carreon

EXHIBIT E

[Logo] *UNUM*

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
207-770-2211
800-822-9103
FAX 207-770-6997

File Copy

August 17, 1994

MICHELLE R. CISNEROS
12435 OLD POMERADO ROAD
POWAY, CA 92064

RE: Michelle R. Cisneros DOB: 11-09-1947
Claim Number: 4S32665592
Policy Number: 334765-001

Dear Ms. Cisneros:

We have examined your disability claim and find that the decision of April 28, 1994 is appropriate. Your claim was not received within the time period required by the policy's Notice and Proof of Claim provision:

a. *Proof of claim must be given to the Company. This must be done no later than 90 days after the end of the elimination period.*

b. *If it is not possible to give proof within these time liimts, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.*

According to information in our records, your most recent period of claimed disability began after your last day of work of June 5, 1992. Based on a June 6, 1992 date of

disability, a 90 day elimination period would have been completed on September 4, 1992. Your application for benefits was received on April 22, 1994, after the time period required by the policy. The decision of April 28, 1994 is therefore correct and we must uphold that decision.

We regret our determination is not favorable; however, please understand that we are strictly limited by the provisions of the policy.

Sincerely,

/s/ Eric Nesbitt
Senior Benefit Analyst

EN / en

[Filed March 1, 1995]

SUPERIOR COURT OF THE
STATE OF CALIFORNIA
FOR THE COUNTY OF SAN DIEGO

Case No. 685986

MICHELLE CISNEROS,
Plaintiff,

vs.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
and DOES 1 through 50, Inclusive,
Defendants.

COMPLAINT FOR:

1. BREACH OF CONTRACT
[Plan Benefits]

2. ATTORNEY'S FEES & COSTS

PLAINTIFF, MICHELLE CISNEROS, AS A FIRST CAUSE OF ACTION AGAINST DEFENDANT, LIFE INSURANCE COMPANY OF NORTH AMERICA, AND DOES 1 THROUGH 50, INCLUSIVE, FOR *BREACH OF CONTRACT*, ALLEGES:

1. The insurance contract that is the subject of this action was entered into within the County of San Diego, State of California.

2. At all relevant times, Plaintiff MICHELLE CISNEROS, (Hereafter "CISNEROS"), was an individual residing in the County of San Diego, State of California.

3. That Defendants, UNUM INSURANCE COMPANY of AMERICA (hereafter "UNUM"), and DOES

1 through 10, inclusive, were and are insurance carriers licensed to do business in the State of California and were and are in the business of issuing and delivering disability insurance policies.

4. The true names and capacities, whether individual, corporate, associate, or otherwise, or Defendants, DOES 1 through 50 inclusive, are unknown to Plaintiff, who therefore sues said defendants by such fictitious names. Plaintiff s informed and believes and therefore alleges that each of the defendants designated herein as a DOE is legally responsible in some manner for the events and happenings referred to here and legally caused injury and damages proximately thereby to Plaintiff as alleged here. Plaintiff will seek leave of this Court to amend this Complaint to insert their true names and capacities in place and instead of the fictitious names when the same become known to Plaintiff.

5. At all relevant times, Defendants, and each of them, were the agents and employees of each of the remaining Defendants, and were at all times acting within the purpose and scope of said agency and employment, and each Defendant has ratified and approved the acts of his agent.

6. Commencing in 1984, Plaintiff was employed by Keenan Supply Company (hereafter "Keenan"), a division of Hajoca Corporation (hereafter "Hajoca") as an office manager.

7. Sometime prior to Plaintiff's employment by Keenan in 1984, Defendant UNUM issued a long term disability insurance policy No. 334765 to Hajoca Corporation, covering Plaintiff as an employee of Keenan (hereafter "The Policy"). Under the terms of the Policy, Plaintiff would be eligible to receive a monthly disability benefit equal to a percentage of Plaintiff's basic monthly earnings in the event she was to become totally disabled. The Policy was entered into by Hajoca within the jurisdiction of the above-entitled court and required the payment of benefits

within the jurisdiction of the above-entitled court for a total amount to be shown at the time of trial.

8. Plaintiff is informed and believes and based upon such information and belief alleges that the Policy that is the subject of this action was part of an employee welfare benefit plan is and was an employee welfare benefit plan, sponsored by UNUM for the purpose of extending benefits to its employees.

9. Plaintiff's employer has paid all premiums due under the Policy to Defendant, UNUM at all relevant times and has performed all obligations under the Policy on its part to be performed. However, Plaintiff was not advised that there existed a long-term disability policy covering her and did not learn of her eligibility for benefits until March 1994.

10. Immediately upon learning of her eligibility for benefits on March 28, 1994, Plaintiff filed a claim with Defendant UNUM for disability benefits under the terms of the Policy due to a work-related injury occurring on August 16, 1989, rendering Plaintiff disabled and unable to perform her duties as an office manager.

11. Since August 16, 1988 and continuing to the present, Plaintiff's medical condition has not changed and she continues to be totally disabled and unable to perform any type of work for which she is qualified.

12. Despite the foregoing, Defendant, on or about April 28, 1994, notified Plaintiff in writing that she was not eligible for any benefits under the Policy. UNUM's stated basis for denial of benefits was arbitrary, erroneous, and unreasonable. Defendant failed to conduct an appropriate investigation or to consider any information which supported the conclusion that Plaintiff was totally disabled and eligible for benefits under the terms of the Policy.

13. Defendants', and each of their denial to Plaintiff of long term disability benefits afforded under the terms

of The Policy, without just cause, constitutes a breach of the disability insurance contract. Plaintiff seeks reimbursement and compensation for any and all expenses she has or will incur as a result of Defendants' failure to pay benefits under the terms of the Policy, in an amount presently unknown, but to be set forth at time of trial.

14. Plaintiff is informed and believes that Defendants, and each of them, intend, at this time, to continue to withhold benefits justly due Plaintiff under the terms of the Policy until and unless ordered to do so by a court of law in the State of California.

15. Defendants, and each of them, have arbitrarily and capriciously breached their obligations under the terms of the Policy.

16. As a direct and proximate result of the aforementioned conduct of Defendants in failing to provide disability benefits to Plaintiff, Plaintiff has been damaged in an amount equal to the amount of benefits she would have been entitled to had Defendants approved, authorized, and paid disability benefits as provided by the terms of the Policy, in an amount according to proof, plus interest.

PLAINTIFF, MICHELLE CISNEROS, FOR A SECOND CAUSE OF ACTION AGAINST ALL DEFENDANTS FOR AN AWARD OF *ATTORNEY'S FEES AND COSTS* ALLEGES:

17. Plaintiff incorporates herein by reference Paragraphs 1 through 16 of the First Cause of Action as though fully set forth in this Cause of Action.

18. As a result of the actions and failings of the Defendants, and each of them, Plaintiff has retained the services of legal counsel and has necessarily incurred attorney's fees and costs in prosecuting this action. Further, Plaintiffs anticipates incurring additional attorney's fees and costs in pursuing this action, all in a final amount

which is currently unknown. Plaintiff therefore requests an award of reasonable attorneys' fees and costs.

WHEREFORE, Plaintiff prays for judgment against Defendants, and each of them, as follows:

1. Damages for failure to provide disability benefits under the Policy, plus interest including prejudgment interest, in a sum to be determined at the time of trial;

2. For attorney's fees reasonably incurred to obtain the Policy Benefits, in a sum to be detemined at the time of trial;

3. For costs of suit incurred herein;

4. For such other and further relief as the court deems just and proper.

DATED: February 16, 1995

LAW OFFICES OF
JEFFREY C. METZGER
A Law Corporation

By: /s/ Jeffrey C. Metzger
JEFFREY C. METZGER
Attorney For Plaintiff
Michelle Cisneros

STATUTORY PROVISIONS

ERISA § 2(a), (b), 29 U.S.C. §§ 1001(a), (b):

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination

of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA § 3(1), (16), 29 U.S.C. § 1002(1), (16):

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

ERISA § 402(a), 29 U.S.C. § 1002(a), (b):

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall—

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D):

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

ERISA § 502(a)(1)(1)(B), 29 U.S.C. § 1132(a)(1)(B):

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

ERISA § 503, 29 U.S.C. § 1133:

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

ERISA § 514(a), (b)(2)(A), (B), (d), 29 U.S.C. § 1144(a), (b)(2)(A), (B), (d):

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar

as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

15 U.S.C. § 1012(a), (b):

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

29 C.F.R. § 2560.503-1(b),(c),(d):

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the proviisons of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) Agrievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.* (1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims

has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary".